**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at optimahealth.com or by calling 1-800-741-9910.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$3,000** person / **$6,000** family combined In-Network and Out-of-Network<br>Doesn't apply to preventive care services or outpatient prescription drugs for preventive care | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For participating providers **$4,000** person / **$8,000** family and non-participating providers **$6,000** person /**$12,000** family<br>The In-Network Out-of-Pocket applies to the Out-of-Network Out-of-Pocket AND the Out-of-Network Out-of-Pocket applies to the In-Network Out-of-Pocket. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, healthcare this plan does not cover, and pre-authorization penalties. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |
| **Does this plan use a network of providers?** | Yes. For a list of participating providers, see **optimahealth.com** or call **1-800-741-9910.** | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan does not cover are listed after page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call **1-800-741-9910** or visit us at optimahealth.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call **1-800-741-9910** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No charge[AD] *AD denotes After Deductible* | 30% Coinsurance[AD] | --none-- |
| | Specialist visit | No charge[AD] | 30% Coinsurance[AD] | --none-- |
| | Other practitioner office visit | No charge[AD] for Chiropractic care | 30% Coinsurance[AD] for Chiropractic care | Benefits may be denied or reduced without pre-authorization by ASHN. Coverage is limited to 20 visits and one appliance, per person per plan year. |
| | Preventive care/ screening/immunization | No charge | 30% Coinsurance[AD] | --none-- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge[AD] | 30% Coinsurance[AD] | --none-- |
| | Imaging (CT/PET scans, MRIs) | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization |
| **If you need drugs to treat your illness or condition.** More information about **prescription drug** | Selected generic drugs | $15 Copayment[AD] for retail prescription/ $38 Copayment[AD] mail order prescription | $15 Copayment[AD] for retail prescription/ $38 Copayment[AD] mail order prescription | Coverage is limited to FDA-approved prescription drugs. For specialty drugs, the out-of-pocket amount is limited to $200 Copayment per retail prescription. If brand drugs are used when a generic is available, you must pay the difference in |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **coverage** is available at optimahealth.com | Select brand and other generic drugs | $40 Copayment[AD] for retail prescription/ $100 Copayment[AD] mail order prescription | $40 Copayment[AD] for retail prescription/ $100 Copayment[AD] mail order prescription | cost plus the Copayment or Coinsurance amount. One Copayment or Coinsurance amount covers up to a 31-day supply retail, and a 90-day supply mail order. Not all drugs are available through a mail order program.<br><br>Deductible does not apply to prescription drugs that are considered by the Plan to be preventive care. |
| | Non-selected brand drugs | $75 Copayment[AD] for retail prescription/ $188 Copayment[AD] mail order prescription | $75 Copayment[AD] for retail prescription/ $188 Copayment[AD] mail order prescription | |
| | Specialty drugs | 20% Coinsurance[AD] for retail prescription | 20% Coinsurance[AD] for retail prescription | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization |
| | Physician/surgeon fees | No charge[AD] | 30% Coinsurance[AD] | --none-- |
| **If you need immediate medical attention** | Emergency room services | No charge[AD] | No charge[AD] | --none-- |
| | Emergency medical transportation | No charge[AD] | 30% Coinsurance[AD] | --none-- |
| | Urgent care | No charge[AD] | 30% Coinsurance[AD] | --none-- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization |
| | Physician/surgeon fee | No charge[AD] | 30% Coinsurance[AD] | --none-- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No charge[AD]<br>No charge for EAP | 30% Coinsurance[AD]<br>EAP not covered | Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy. EAP coverage is limited to a 5-visit maximum combined benefit per presenting issue by Optima EAP providers only. |
| | Mental/Behavioral health inpatient services | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization for all inpatient services. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Substance use disorder outpatient services | No charge[AD]<br>No charge for EAP | 30% Coinsurance[AD]<br>EAP not covered | Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy. EAP coverage is limited to a 5-visit maximum combined benefit per presenting issue by Optima EAP providers only. |
| | Substance use disorder inpatient services | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization for all inpatient services. |
| **If you are pregnant** | Prenatal and postnatal care | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization for prenatal services |
| | Delivery and all inpatient services | No charge[AD] | 30% Coinsurance[AD] | --none-- |
| **If you need help recovering or have other special health needs** | Home health care | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization. Coverage is limited to combined in- and out-of network 100 visits per person per plan year. |
| | Rehabilitation services | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization. Coverage is limited to combined in- and out-of- network of: 30 combined visits for PT and OT; 30 visits for cardiac, pulmonary, vascular, and vestibular therapies; and 30 visits for ST, per person per plan year. |
| | Habilitation services | Not covered | Not covered | --none-- |
| | Skilled nursing care | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization. Coverage is limited to combined in- and out-of network 100 days per person per stay. |
| | Durable medical equipment | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization for single items over $750, all rental items, and repair and replacement. |
| | Hospice service | No charge[AD] | 30% Coinsurance[AD] | Benefits may be denied or reduced without pre-authorization |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If your child needs dental or eye care** | Eye exam | No charge | $30 Reimbursement | Coverage is limited to one exam every 12 months from participating EyeMed providers. Additional cost may apply for contact lens exam. |
| | Glasses | Not covered | Not covered | --none-- |
| | Dental check-up | Not covered | Not covered | --none-- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Glasses
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic Care
- Routine Eye Care (Adult)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-741-9910. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

For group health coverage subject to ERISA, you may contact Member Services at the number on the back of your member ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, 1-877-310-6560 (Toll Free), or bureauofinsurance@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact Member Services at the number on the back of your member ID card, or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, 1-877-310-6560 (Toll Free), or bureauofinsurance@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA, 23218, 1-877-310-6560, or http://www.scc.virginia.gov/boibureauofinsurance@scc.virginia.gov.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-741-9910.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-741-9910.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-741-9910.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-741-9910.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,520
- **Patient pays** $3,020

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $3,000 |
| Copays | $20 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$3,020** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,380
- **Patient pays** $3,020

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $2,420 |
| Copays | $600 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$3,020** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.